

Tips

Press TAB to go to next field, or use mouse to position cursor in desired field, and click to enter text.

Press SHIFT + TAB to return to previous field.

You can select the page you wish to view or work on by clicking on that page in the “Bookmarks” panel on this window’s left panel.

Notice

If you have Adobe® Acrobat® Reader® versions 4.0 or 5.0, you can save a blank form to your computer, which you can fill out at your leisure.

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State of New Jersey
Department of Labor
Office of Special Compensation Funds
PO Box 399
Trenton, New Jersey 08625-0399

Complaint of Discrimination

N.J.S.A. 34:15-39.1 et seq.

The New Jersey Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.) provides that it shall be unlawful for an employer to discharge or otherwise discriminate against an employee because that employee has filed or has attempted to file a claim for workers' compensation benefits or has testified or has planned to testify in any proceeding before the Division of Workers' Compensation. This complaint is to be completed by an employee who alleges such discrimination.

01. Your Name

02. Your Social Security Number

03. Your complete home address

ZIP code

04. Your home telephone number

05. If employed, your daytime telephone number

06. Nature of complaint (check one)

a. I believe that I was discriminated against because of my filing or attempting to file a workers' compensation claim.

b. I believe that I was discriminated against because of my testimony or plans to testify in a workers' compensation proceeding.

07. Name of employer

08. New Jersey Employer Identification number (if known)

09. Complete employer address

ZIP code

10. Employer agent name

11. Employer agent telephone number

COMPLETE ITEMS #12 THROUGH #20 ONLY IF YOU HAVE CHECKED BOX "a" IN EACH ITEM #06, ABOVE.

12. Name of employer's Workers' Compensation Insurance carrier

13. Have you filed a claim with this carrier?

No Yes, Claim #

14. Have you filed a claim with the NJ Div. of Workers Compensation?

15. Date of accident/illness

No Yes, Claim Petition #

16. Your occupation at time of accident/illness

17. Nature of your disability

18. Your gross weekly wages at time of accident/illness

\$ per week

19. Your job duties at time of accident/illness

20. Are you currently able to perform these duties? (check one)

Yes No

Complete Items #21 through #26 only if you have checked box "b" in item 06

21. Full name of Petitioner in Workers' Compensation case
22. Claim Petition number
23. Did you testify in this case? (check one)
- No Yes (if Yes, complete item #24)
24. Date and location of testimony
- date
25. Are you scheduled to testify in this case? (check one)
- No Yes (if Yes, complete item #26)
26. Scheduled date and location of testimony
- date
27. Date of termination or other personnel action
28. Reason given by employer for action
29. If currently employed, employer's name and address
30. If employed, your current weekly gross wages
- \$ Per Week
31. State here, and/or on attached sheets, the reason for your alleging discrimination

State of New Jersey, County of

, of full age, being duly sworn according to law, on his/her oath deposes and says: That he/she is the complainant named in the foregoing complaint; that he/she has read the same; and that the matters and thing therein set forth are true according to the best of his/her knowledge and belief.

Employee Signature

Subscribed and sworn before me this

day of

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